REPORT ON EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS PURSUANT TO G.L. c. 118G, § 6½(b)

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June 27, 2011

KEY FINDINGS

1. There is wide variation in the payments made by health insurers to providers that is not adequately explained by differences in quality of care.

KEY FINDINGS

2. Globally paid providers do not have consistently lower total medical expenses.

KEY FINDINGS

3. Total medical spending is on average higher for the care of health plan members with higher incomes.

KEY FINDINGS

4. Tiered and limited network products have increased consumer engagement in value-based purchasing decisions.

KEY FINDINGS

5. Preferred Provider Organization (“PPO”) health plans, unlike Health Maintenance Organization (“HMO”) health plans, create significant impediments for providers to coordinate patient care because PPO plans are not designed around primary care providers who have the information and authority necessary to coordinate the provision of health care effectively.

KEY FINDINGS

6. Health care provider organizations designed around primary care can coordinate care effectively (1) through a variety of organizational models, (2) provided they have appropriate data and resources, and (3) while global payments may encourage care coordination, they pose significant challenges.

EXAMINATION APPROACH

- This year, we issued 30 subpoenas for documents and testimony to 6 health plans and 16 providers.
- We conducted more than three dozen interviews and meetings with providers, insurers, health care experts, consumer advocates, employers, and other key stakeholders.
- We engaged experts with extensive experience in the Massachusetts health care market.
- We greatly appreciate the courtesy and cooperation of payers and providers who provided information for this examination, and look forward to continuing our collective efforts.

MEASURING HEALTH CARE COSTS

- PRICE: The contractually negotiated amount that an insurance company pays a health care provider for providing health care services; we reviewed relative price information, which shows the prices paid by health plans to providers for all services in aggregate as compared to other providers in the health plan network.

- TOTAL MEDICAL EXPENSES (TME): The total cost of all the care that a patient receives, including the payments by the health plan for the care of the patient, and any copayment or deductible for which the patient is responsible. TME reflects *both* price of services and volume of services.

HEALTH CARE PAYMENT METHODS

- FEE-FOR-SERVICE (FFS): A payment arrangement under which health insurers pay each claim submitted by health care providers on a claim by claim basis, based on the negotiated contractual price for each service.

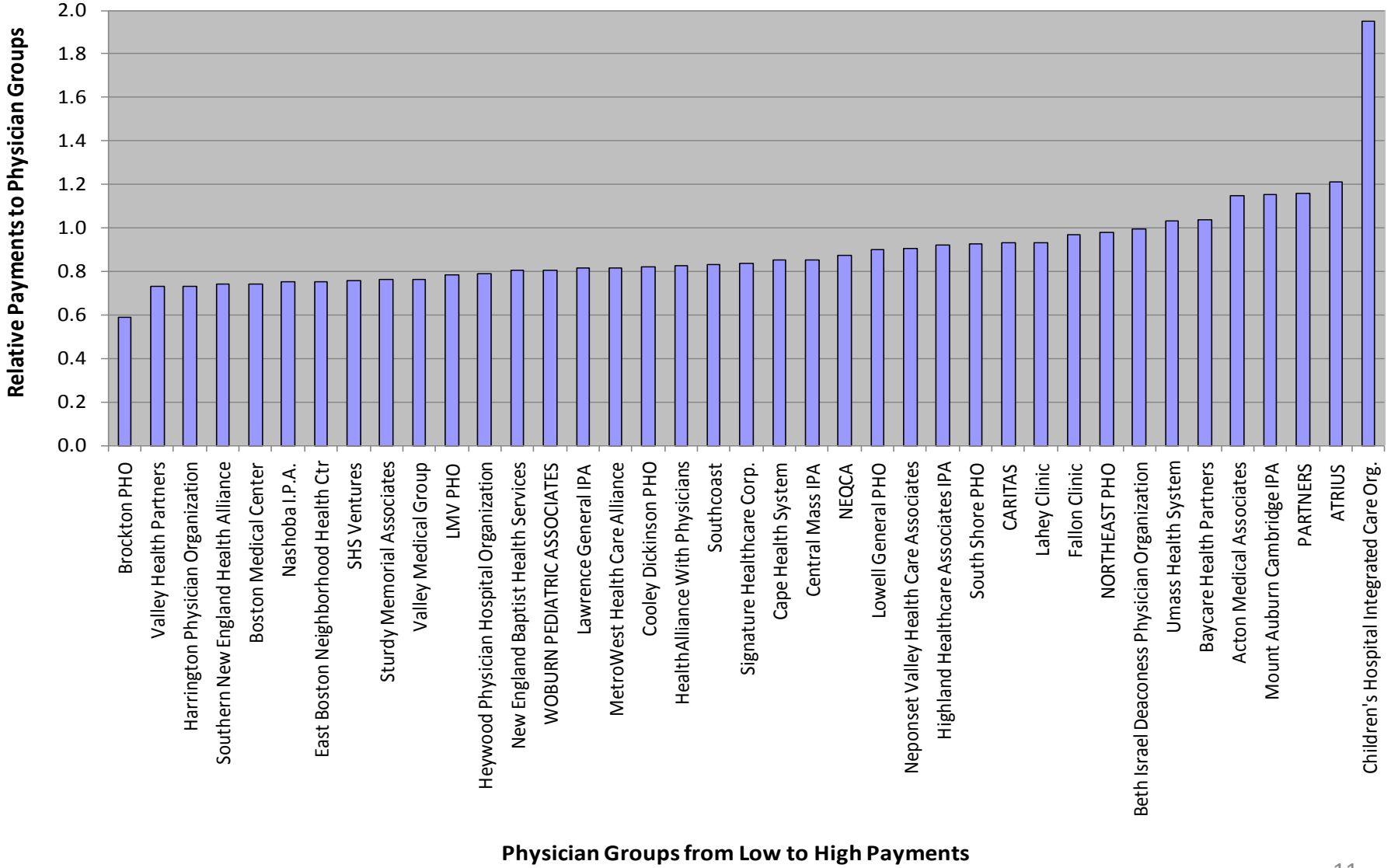
- GLOBAL RISK: Under global risk arrangements, health care providers are put on a budget for the care of their patients. At the end of the year, if the provider is under its budget, it earns a surplus; if the provider is over its budget, it pays a deficit to the insurer.

MEASURING HEALTH CARE DELIVERY

- QUALITY: We reviewed publicly available quality data from state and national government and non-profit organizations that are well-vetted and widely accepted, including measures from Centers for Medicare and Medicaid Services (CMS), Massachusetts Data Analysis Center (Mass-DAC), and Massachusetts Health Quality Partners (MHQP).

- CARE COORDINATION: Quality care that is primary care-based and managed over time and across health care settings.

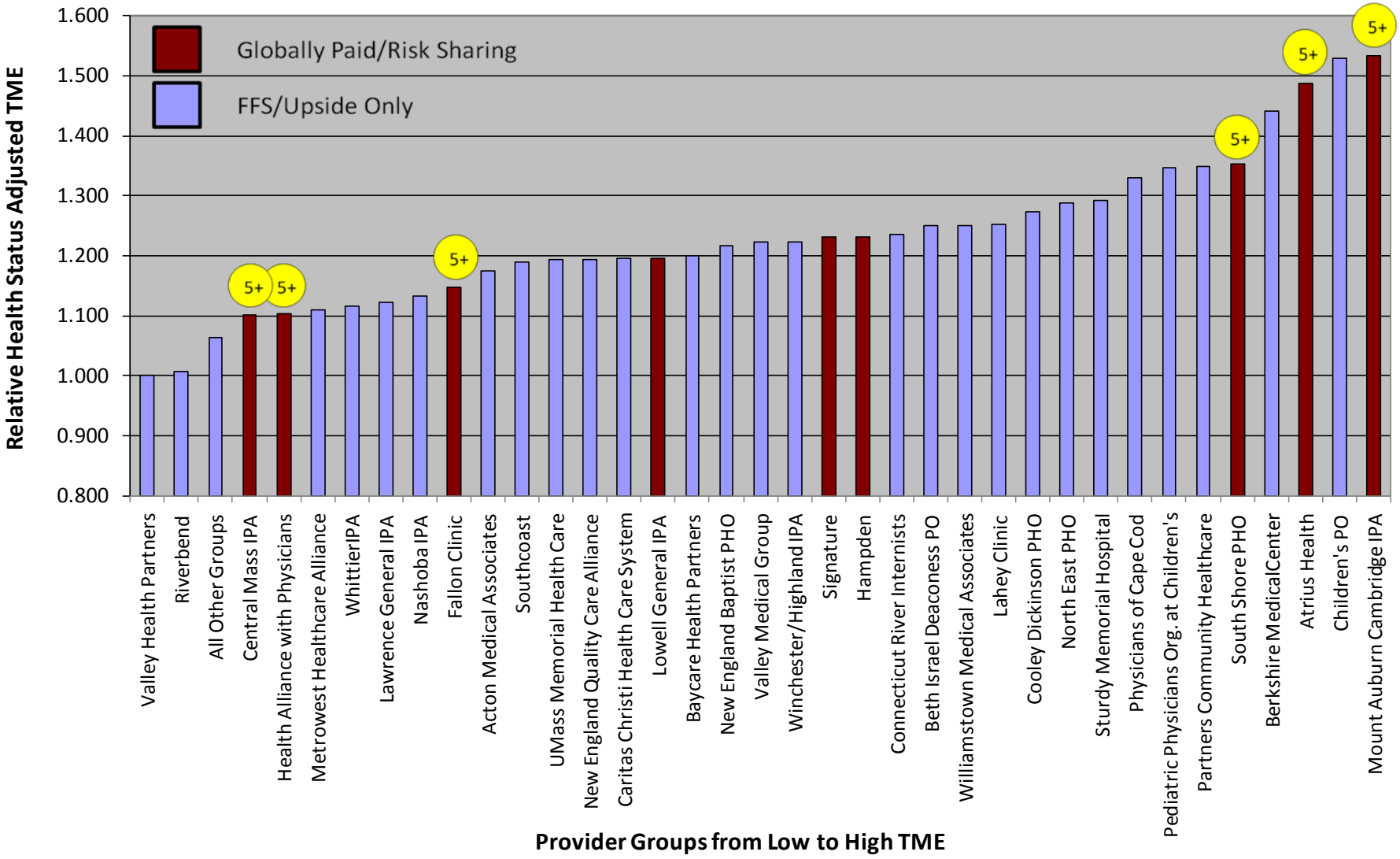
FINDING #1: PRICES PAID TO PROVIDERS CONTINUED TO VARY SIGNIFICANTLY IN 2009



FINDING #1: THERE ARE ALSO VARIATIONS IN GLOBAL PAYMENTS

- We found wide variations in the health status adjusted global payments made by health plans to at-risk providers.
- For example, in one health plan's network in 2009, one globally paid provider had a health status adjusted budget of approximately $428 per member, per month, while another had a health status adjusted budget of only $276 per member per month.

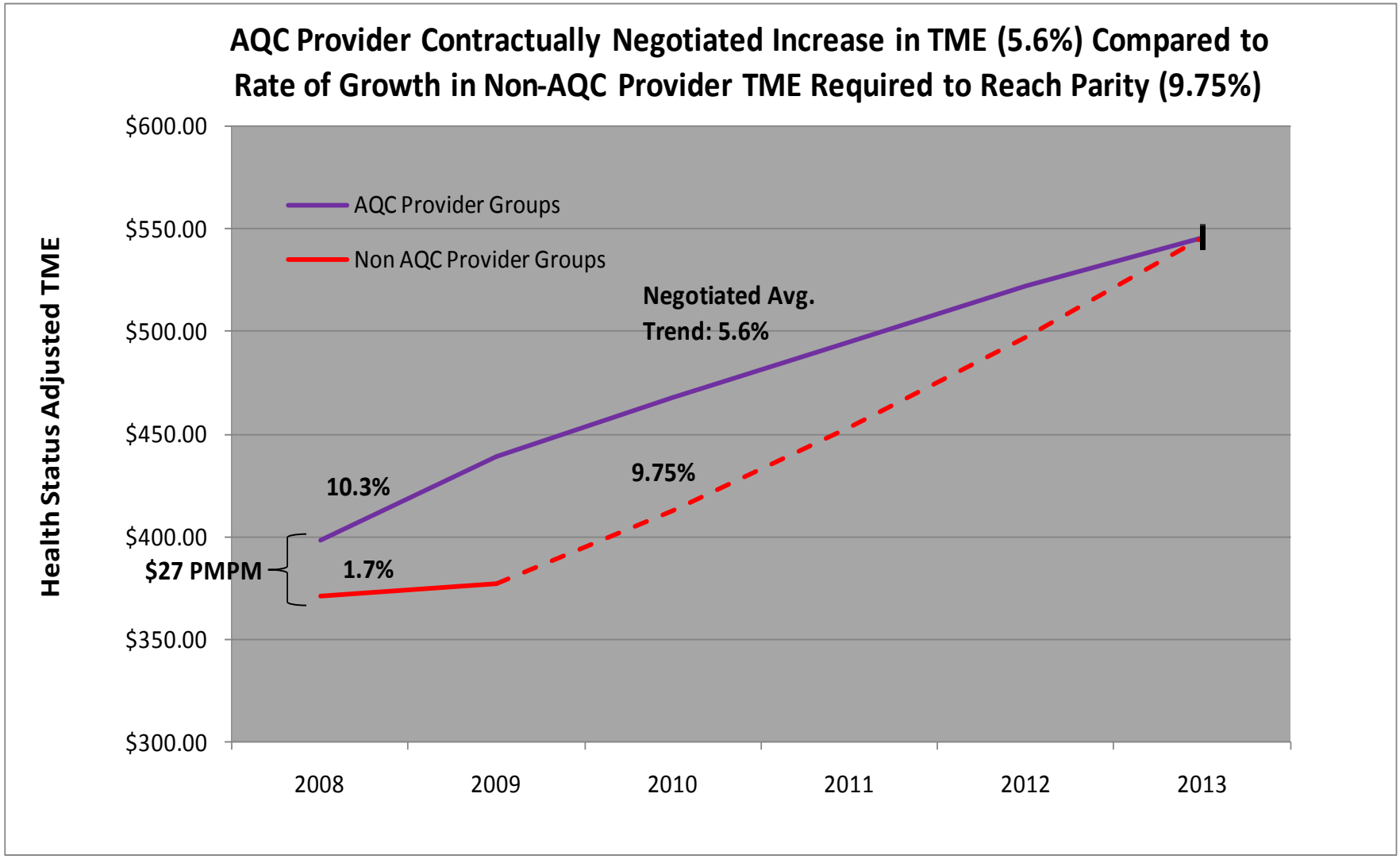
FINDING #2: GLOBALLY PAID PROVIDERS DO NOT HAVE CONSISTENTLY LOWER TOTAL MEDICAL EXPENSES



FINDING #2: GLOBAL PAYMENTS POSE SIGNIFICANT CHALLENGES

- Many providers in Massachusetts do not have experience managing risk.
- Bearing risk through global payments requires significant investment to develop the capacity to effectively manage risk.
- We need to ensure that the incentive to manage risk contracts does not lead providers to avoid patients whose care may be more difficult to manage.

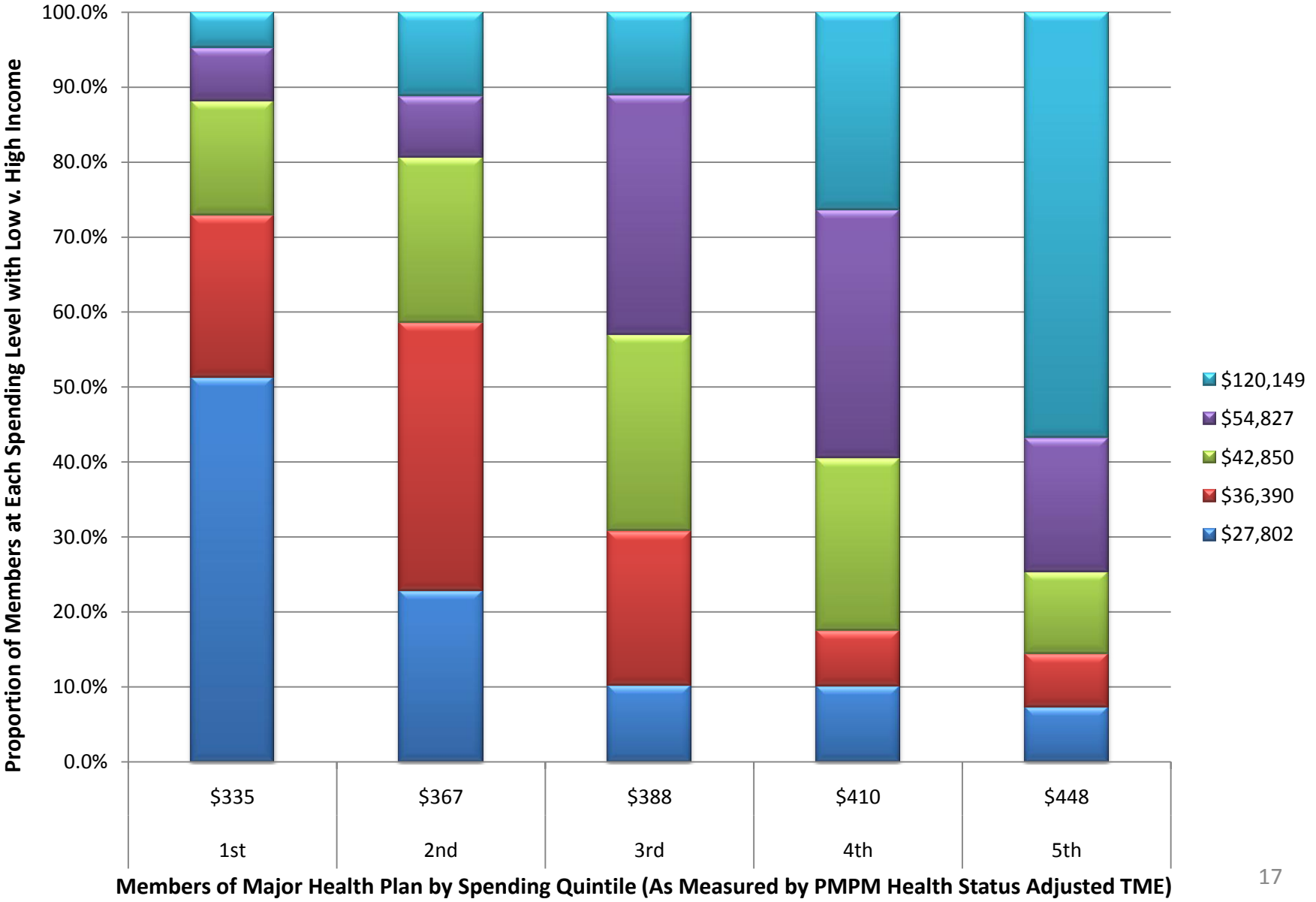
FINDING #2: 2009 AQC PARTICIPANTS ARE UNLIKELY TO HAVE LOWER TME THAN NON-AQC PARTICIPANTS BY 2013



FINDING #3: TOTAL MEDICAL SPENDING IS HIGHER FOR COMMERCIAL HEALTH PLAN MEMBERS FROM HIGHER INCOME ZIP CODES

- We received TME information for all commercial members in the BCBS, THP, and HPHC networks.
- For each Massachusetts zip code, we examined average TME for members living in that zip code with average income for that zip code, as reported on 2007 federal income tax returns.
- The next graph shows that total medical spending for the care of patients from lower-income zip codes is lower on a health-status adjusted basis than total medical spending on the care of patients from higher-income zip codes.

FINDING #3: TOTAL MEDICAL SPENDING IS HIGHER FOR COMMERCIAL HEALTH PLAN MEMBERS FROM HIGHER INCOME ZIP CODES (CONT'D)



FINDING #4: TIERED AND LIMITED NETWORK PRODUCTS HAVE INCREASED CONSUMER ENGAGEMENT IN VALUE-BASED PURCHASING DECISIONS

- Currently, consumers have little to no incentive to switch to more efficient providers because they are not rewarded with the cost savings associated with that switch.

- As a result: (1) consumers are de-sensitized from value-based choices and (2) providers are discouraged from competing on value.

- There have been recent developments in tiered and limited network products; these types of innovative products should be encouraged.

FINDING #5: PPO HEALTH PLANS CREATE SIGNIFICANT IMPEDIMENTS FOR PROVIDERS TO COORDINATE PATIENT CARE

- We found that primary care providers, with adequate resources and data, are the foundation of effective care coordination.
- Preferred provider organization (PPO) plans do not require selection of a primary care provider, and therefore are inconsistent with structured approaches to improving care coordination.
- We found that enrollment in PPO plans is increasing.

FINDING #6: PROVIDERS CAN COORDINATE PATIENT CARE, REGARDLESS OF THEIR ORGANIZATIONAL STRUCTURE

- A variety of provider organizational models can deliver high-quality, coordinated care.
- Care coordination and measurement of system-wide performance is hampered by the lack of transparent and reliable information.

Bela Gorman, FSA, MAAA

MOVING FORWARD ON COST CONTAINMENT

1. Promote tiered and limited network products to increase value-based purchasing decisions.

MOVING FORWARD ON COST CONTAINMENT

2. Reduce health care price distortions through temporary statutory restrictions until tiered and limited network products and commercial market transparency can improve market function.

MOVING FORWARD ON COST CONTAINMENT

3. Encourage consumers to select a primary care provider who can assist consumers in coordinating care based on each consumer's needs and best interests.

MOVING FORWARD ON COST CONTAINMENT

4. Promote coordination of patient care through primary care providers by recognizing the need to improve funding of care coordination, including the infrastructure necessary to coordinate care, and by giving providers timely access to relevant patient data regardless of their size or payment methodology.

MOVING FORWARD ON COST CONTAINMENT

5. Consider steps to improve the use of the all payer claims database ("APCD") by: (i) developing reports for providers and the public to guide development of patient care coordination improvements and system accountability, and (ii) increasing the standardization of claim level submissions by reducing differences in how payers report payment level information.

MOVING FORWARD ON COST CONTAINMENT

6. Develop appropriate regulations, solvency standards, and oversight for providers who contract to manage the risk of insured and self-insured populations.

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